

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form RM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div> <div>091779</div> <div>091772</div> </div>									
<div> <div>1. DECEASED-NAME (Type or Print)</div> <div>First Middle Last</div> <div>Clive James Bassett</div> </div>									
<div> <div>2a. DATE KNOWN OF DEATH</div> <div>Month Day Year</div> <div>6 25 69</div> </div>									
<div> <div>3. SEX</div> <div>Male</div> </div>									
<div> <div>4. RACE</div> <div>White</div> </div>									
<div> <div>5. DATE OF BIRTH</div> <div>10-20-07</div> </div>									
<div> <div>6. AGE (In years last birthday)</div> <div>61 YRS</div> </div>									
<div> <div>7c. DATE PRONOUNCED DEAD</div> <div>Month Day Year</div> <div>6 26 1969</div> </div>									
<div> <div>7a. BIRTHPLACE (State or foreign country)</div> <div>Maryland</div> </div>									
<div> <div>7b. CITIZEN OF WHAT COUNTRY?</div> <div>U.S.A.</div> </div>									
<div> <div>8. MARRIED</div> <div>NEVER MARRIED</div> <div>WIDOWED</div> <div>DIVORCED</div> </div>									
<div> <div>9. COUNTY OF DEATH</div> <div>Worcester</div> </div>									
<div> <div>10. CITY OR TOWN OF DEATH</div> <div>Berlin R.D. 3</div> </div>									
<div> <div>11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)</div> <div>Berlin R.D. 3</div> </div>									
<div> <div>12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)</div> <div>Farming</div> </div>									
<div> <div>12b. KIND OF BUSINESS OR INDUSTRY</div> <div>Farming</div> </div>									
<div> <div>13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE</div> <div>Md.</div> </div>									
<div> <div>13b. COUNTY</div> <div>Worcester</div> </div>									
<div> <div>13c. CITY OR TOWN</div> <div>Berlin</div> </div>									
<div> <div>13d. INSIDE CITY LIMITS?</div> <div>YES</div> <div>NO</div> </div>									
<div> <div>13e. STREET AND NUMBER</div> <div>R.D. 3</div> </div>									
<div> <div>14. FATHER'S NAME</div> <div>First Middle Last</div> <div>Claude Francis Bassett</div> </div>									
<div> <div>15. MOTHER'S MAIDEN NAME</div> <div>First Middle Last</div> <div>Edna Holloway</div> </div>									
<div> <div>16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)</div> <div>No</div> </div>									
<div> <div>16b. SOCIAL SECURITY NO.</div> <div>215-36-1310</div> </div>									
<div> <div>17. INFORMANT (son-in-law)</div> <div>Robert Ewell</div> </div>									
<div> <div>ADDRESS</div> <div>Berlin, Md. R.D. 3</div> </div>									
<div> <div>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</div> </div>									
<div> <div>PART 1. DEATH WAS CAUSED BY:</div> </div>									
<div> <div>IMMEDIATE CAUSE (a)</div> <div>Pneumonia / Accidental drowning</div> </div>									
<div> <div>DUE TO, OR AS A CONSEQUENCE OF</div> </div>									
<div> <div>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</div> </div>									
<div> <div>(b)</div> <div>DUE TO, OR AS A CONSEQUENCE OF</div> </div>									
<div> <div>(c)</div> <div>DUE TO, OR AS A CONSEQUENCE OF</div> </div>									
<div> <div>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</div> </div>									
<div> <div>19a. DATE OF OPERATION</div> </div>									
<div> <div>19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?</div> </div>									
<div> <div>20. AUTOPSY?</div> <div>YES</div> <div>NO</div> </div>									
<div> <div>21a. EXTERNAL CAUSE WAS PRIMARY</div> <div>OR CONTRIBUTING</div> <div>CAUSE OF DEATH</div> </div>									
<div> <div>21b. TIME OF INJURY</div> <div>Month, Day, Year</div> <div>Hour A.M. P.M.</div> <div>19</div> </div>									
<div> <div>21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)</div> </div>									
<div> <div>21d. INJURY OCCURRED</div> <div>WHILE AT WORK</div> <div>NOT WHILE AT WORK</div> </div>									
<div> <div>21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)</div> </div>									
<div> <div>21f. LOCATION</div> <div>Street or R.F.D. No.</div> <div>City or Town</div> <div>County</div> <div>State</div> </div>									
<div> <div>22a. I certify that I took charge of the remains described above, held an Autopsy</div> <div>Inspection</div> <div>Inquiry</div> <div>and in my opinion death resulted from:</div> <div>Natural causes</div> <div>Accident</div> <div>Suicide</div> <div>Homicide</div> <div>Undetermined manner</div> </div>									
<div> <div>ACTUAL SIGNATURE</div> <div>Clifford E. Schott</div> <div>M.D.</div> </div>									
<div> <div>EXAMINER'S NAME (Type)</div> <div>Clifford E. Schott, M.D.</div> </div>									
<div> <div>22b. DATE SIGNED</div> <div>Acting 6-26-69</div> </div>									
<div> <div>ADDRESS (Street, city, town, or county)</div> <div>Worcester Co.</div> </div>									
<div> <div>23a. BURIAL, CREMATION, REMOVAL (Specify)</div> <div>Burial</div> </div>									
<div> <div>23b. DATE</div> <div>6-29-69</div> </div>									
<div> <div>23c. NAME OF CEMETERY OR CREMATORY</div> <div>Sunset Memorial Park</div> </div>									
<div> <div>23d. LOCATION (City or Town) (County) (State)</div> <div>Berlin Worcester Md.</div> </div>									
<div> <div>24. FUNERAL DIRECTOR</div> <div>ADDRESS</div> <div>Anna A. Burbage Berlin, Maryland</div> </div>									
<div> <div>25a. REC'D BY REGISTRAR</div> <div>DATE</div> <div>JUL 2 1969</div> </div>									
<div> <div>25b. REGISTRAR'S SIGNATURE</div> <div>Richard J. Jones</div> </div>									

05120

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

05120

PLANT INDUSTRY
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DEPARTMENT OF AGRICULTURE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR
Sallie Mary Beauchamp						June 2, 1969			11:45 PM
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
Female	White		June 16, 1868			100 YRS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		USA				Worcester Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Snow Hill		211 S. Washington St.			Housewife		Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Worcester		Snow Hill		YES		211 S. Washington St.
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Alison Gravenor			Martha Purnell						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
No			Unknown		Mrs. Edith B. Carmean, Snow Hill Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 485X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Chronic Brain Syndrome</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (1) this hospital attended the deceased from June 2, 1969, to June 2, 1969, that (1) we last saw the deceased alive on June 2, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) we (did) (did not) view the body after death.									
22b. SIGNATURE Lloyd O. Long, M.D.					DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6-4-69
22d. PHYSICIAN'S NAME (Type) Lloyd O. Long, M.D.					22e. ADDRESS 104 N. Bay St., Snow Hill, Md. 21003				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		June 5, 1969		Whatcoat Meth.		Snow Hill Maryland			
24. FUNERAL DIRECTOR Norman F. Morris, Snow Hill, Md.					25a. REC'D BY REGISTRAR DATE JUN 5 1969		25b. REGISTRAR'S SIGNATURE Charles Judge		

MEDICAL CERTIFICATION

02180

1. The first part of the document is a list of names and titles, including "The Hon. Mr. Justice" and "The Hon. Mr. Justice".

**FOR STATE
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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										09174		
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or Print)			First		Middle		Last		2a. DATE KNOWN OF DEATH			2b. HOUR
Stella			M.		Bromley		2a. DATE KNOWN OF DEATH			2b. HOUR		
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		7c. DATE PRONOUNCED DEAD			7d. HOUR
Female			White		May 11, 1892		77 YRS.		June 9			19 69
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			
Maryland			USA						Worcester			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)						12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Snow Hill			110 N. Washington St.						Newswoman		Newspaper	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Maryland			Worcester			Snow Hill			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		110 N. Washington St.	
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME			First
George C. Shockley									Laura G. Hearne			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
No			213 017586			Mr. Base Shockley			Snow Hill, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) Myocardial Infarction										1 minute		
DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
(b) Arteriosclerotic Heart Disease										4 years		
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?			
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
			P.M. 19									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town			
									County			
									State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER						22b. DATE SIGNED			
Lloyd O. Long									June 11, 1969			
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER									
104 N. Bay St., Snow Hill, Md. 21863			ADDRESS (Street, city, town, or county)									
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial			June 12, 1969		Bates Methodist			Snow Hill, Maryland				
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR						25b. REGISTRAR'S SIGNATURE			
Zerman F. Lanning			DATE JUN 16 1969						Charles Judge			

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May 1, 1910
104 N. 2nd St., St. Paul, Minn.

[Faint, mostly illegible handwritten text at the bottom of the page.]

422X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09182

09175

1. PLACE OF DEATH a. COUNTY <i>Worcester</i> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Berlin</i> c. LENGTH OF STAY IN 1b <i>5 days</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Berlin Nursing Home</i>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Worcester</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Berlin</i> d. STREET ADDRESS <i>R. 7, D.</i> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Ida</i> Middle <i>Jane</i> Last <i>Donaway</i> 4. DATE OF DEATH Month <i>June</i> Day <i>10</i> Year <i>1969</i>				5. SEX <i>Female</i> 6. COLOR OR RACE <i>white</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <i>Apr. 11, 1881</i> 9. AGE (In years last birthday) <i>88</i> yrs. IF UNDER 1 YEAR Months <i>8</i> Days <i>10</i> IF UNDER 24 HRS. Hours <i>10</i> Min. <i>10</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> 10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Worcester Co., Md.</i> 12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>		13. FATHER'S NAME <i>John T. Littleton</i> 14. MOTHER'S MAIDEN NAME <i>Ellen Cooper</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> 16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <i>Harry Donaway</i> Address <i>Berlin, Md.</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocarditis</i> DUE TO <i>Serious</i> (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>4/1/69</i> 19 <i>6/10/69</i> 19 , that (I) (we) last saw the deceased alive on <i>6/9/69</i> 19 , and that death occurred at <i>10:30 AM</i> from the causes and on the date stated above.							
22a. SIGNATURE <i>Clifford E. Schott</i> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <i>Clifford E. Schott M.D.</i> 22d. ADDRESS <i>Berlin, Md.</i>				22b. DATE SIGNED			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> 23b. DATE THEREOF <i>Apr. 13, 1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rehoboth</i> 23d. LOCATION (City, town or county) (State) <i>Whaleysville Md.</i>		24. FUNERAL DIRECTOR <i>Richard T. Watson</i> ADDRESS <i>Seabrook, Del.</i>			
25a. REG'D BY REGISTRAR <i>JUN 18 1969</i> 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>							

MEDICAL CERTIFICATION

82100

(14)

(15)

10.10.10

10.10.10

10.10.10

10.10.10

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

09183

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09176

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
Elizabeth			Hodnett			Month Day Year			M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			2d. HOUR
Female	Negro	Jan. 22 1924	45 YRS.	MONTHS	DAYS	HOURS	MIN.	Month Day Year			M
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH			Md.
Virginia		U.S.A.		WIDOWED		DIVORCED		Worcester			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Snow Hill						Housewife			Run Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
Maryland			Worcester			Snow Hill			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
George Jackson			Louise Unknown								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
No			Unknown			Herman Hodnett			Snow Hill, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a)										2 yrs	
303.2 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										15 yrs	
(b) Chronic Alcoholism											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			HOUR A.M. P.M. 19								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town		County State	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED					
EXAMINER'S NAME (Type)			M.D.			ASSISTANT MEDICAL EXAMINER			6-28-69		
Robert C. LaMar, M. D. 104 Bay Street, Snow Hill, Md.			DEPUTY MEDICAL EXAMINER			ADDRESS (Street, city, town, or county)			Worcester Co.		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Removal		June 28, 1969		Williams Funeral Home			Roanoke, Virginia				
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Herman F. Fiermi, Snow Hill, Md.								DATE JUN 30 1969		Charles Judge	

58120

100-443887-1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 2 and 3, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
09184 CERTIFICATE OF DEATH 09177									
1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR M.	
WILLIAM BROOKS LEWIS						June 27, 1969		6:30	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS	
Male		White		Oct. 3, 1905		63 YRS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Virginia		U.S.A.				WORCESTER		Md	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Pocomoke City		R.F.D. 2		Mechanic		Food Processing			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Worcester		Pocomoke				R.F.D. 2	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
Charles			--		Lewis	Roxie			--- Wessells
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
No			--		228-01-4505 Mrs Vivian C. Lewis, Pocomoke City, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Acute Myocardial Infarction								Minutes	
Coronary Artery Disease								14 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from April 15, 1955 to June 27, 1969, that (I) (we) lost saw the deceased alive on June 27, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Charles W. Trader, M.D.					22c. DATE SIGNED 6-28-69		22d. PHYSICIAN'S NAME (Type) Charles W. Trader, M.D.		
22e. ADDRESS Pocomoke, Maryland.									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City or Town) (County) (State)			
Burial		6-29-1969		First Baptist		Pocomoke City-Wor.-Md.			
24. FUNERAL DIRECTOR Robert H. Watson Pocomoke City, Md.					25a. REC'D BY REGISTRAR JUL 2 1969		25b. REGISTRAR'S SIGNATURE Charles Judge		



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item 1. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

Item 22a Film 414
7-3-69
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09185 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09178

1 PLACE OF DEATH a. COUNTY WORCESTER MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE FLORIDA b. COUNTY <input checked="" type="checkbox"/>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL New Hill		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Miami	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 915 NW 3d Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) PAUL		4 DATE OF DEATH Month Day Year 6 20 1969	
5 SEX MALE	6 COLOR OR RACE NEGRO	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 3-26-1913
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b KIND OF BUSINESS OR INDUSTRY	9 AGE (In years last birthday) 56 yrs
11 BIRTHPLACE (State or foreign country) New Orleans		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME unknown		14 MOTHER'S MAIDEN NAME unknown	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO. 227-46-588	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DROWNING 184X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 15 min.	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) UNKNOWN	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> hot While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) [Signature]		22. DATE SIGNED 6/25/69	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 6-29-69	23c NAME OF CEMETERY OR CREMATORY Westview Comm Cem
24 FUNERAL DIRECTOR Louette D. Jolley Rt. 2 Precinct		23d LOCATION (City or town) (County) (State) Pompano Beach Broward Fla	25a REC'D BY REGISTRAR [Signature]
25b REGISTRAR'S SIGNATURE [Signature]		DATE JUN 30 1969	

09186

CERTIFICATE OF DEATH

09179

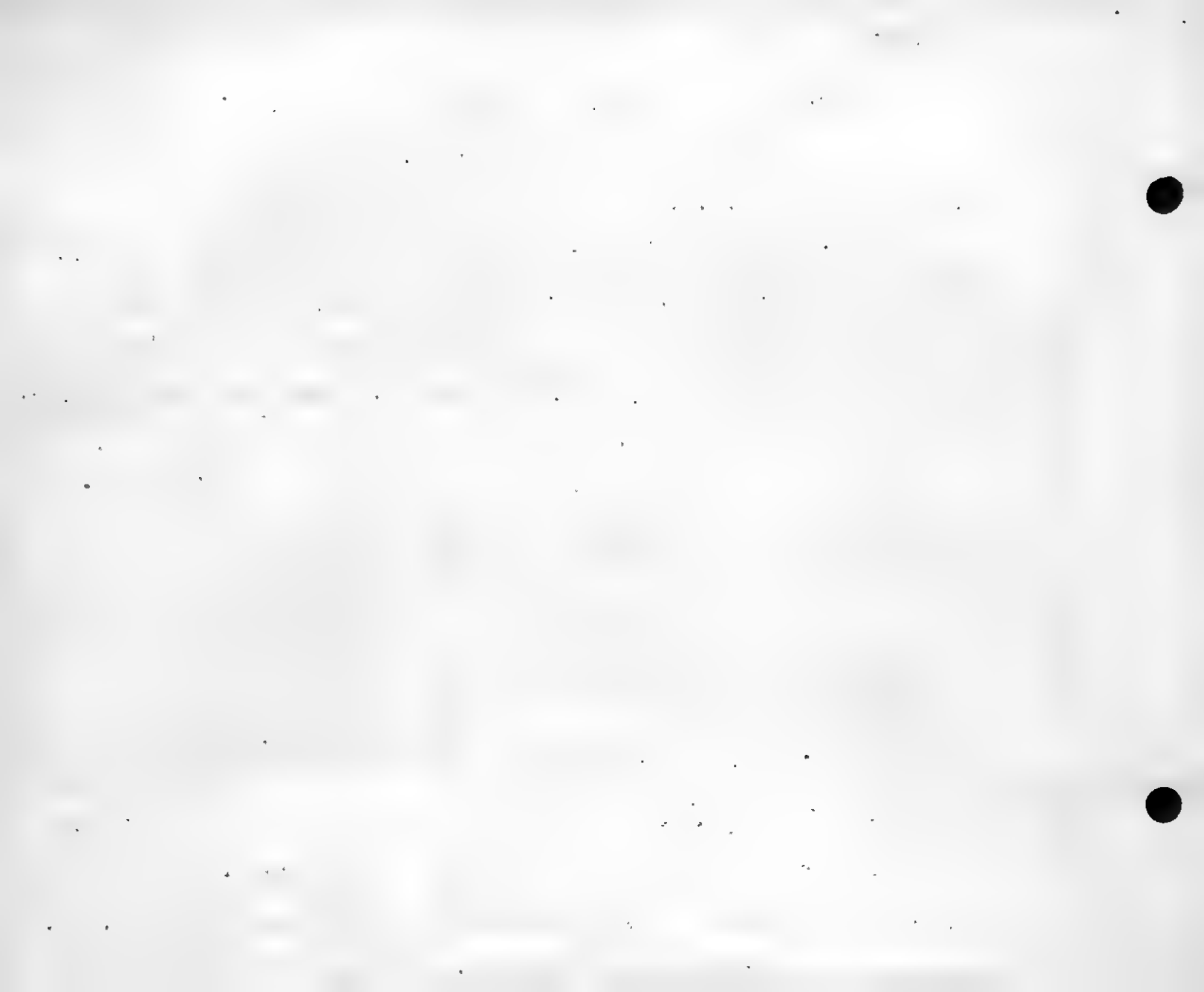
1. DECEASED NAME (Type or print) BERNARD FRANKLIN MOORE			2a. DATE OF DEATH Month June Day 23 Year 1969			2b. HOUR 1:50 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH Feb. 12, 1889		6. AGE (In years last birthday) 80 YRS.	
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WORCESTER Md.	
10. CITY OR TOWN OF DEATH Pocomoke City		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hartley Hall		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Contractor		12b. KIND OF BUSINESS OR INDUSTRIAL BUILDING General Building	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Worcester		13c. CITY OR TOWN Pocomoke		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 616 Market Street							
14. FATHER'S NAME First Middle Last Laban Crippen Moore			15. MOTHER'S MAIDEN NAME First Middle Last Mary Jane Thomas				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? Yes		16b. SOCIAL SECURITY NO. 214-32-6668		17. INFORMANT Address Mrs Eula L. Moore, Pocomoke City, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic Carcinoma of Lung, Liver, Months 15X DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of the Prostate 3 years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from MAY , 19 68 , to June 23, 1969 , that (I) (we) last saw the deceased alive on June 23, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.							
22b. SIGNATURE Charles W. Trader M.D.		22c. DATE SIGNED 6-25-69		22d. PHYSICIAN'S NAME (Type) Charles W. Trader, M.D., 302 Market St., Pocomoke, Maryland.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6-26-1969		23c. NAME OF CEMETERY First Baptist		23d. LOCATION (City or Town) (County) (State) Pocomoke City-Wor.-Md.	
24. FUNERAL DIRECTOR Robert H. Watson		ADDRESS Pocomoke City, Md.		25a. REC'D BY REGISTRAR JUL 2 1969		25b. REGISTRAR'S SIGNATURE Charles W. Trader	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

09187

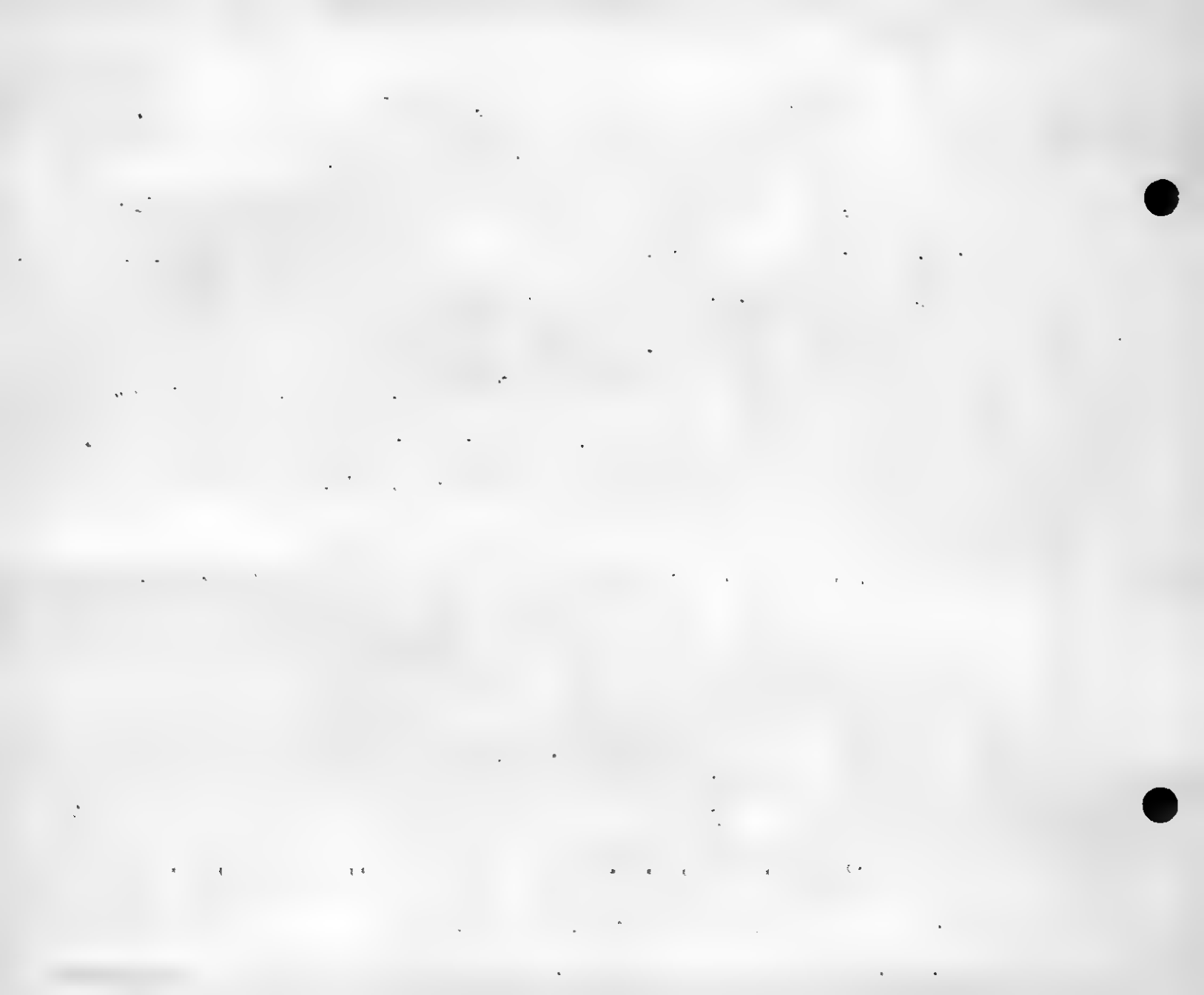
09180

1 DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR		
Ernest Lee Nicholson Jr.						June 16 1969			5 P M		
3. SEX		4 RACE		5 DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
Male		White		June 28, 1915		53 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		U.S.A.				Worcester Md					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Newark		BFD # 1				Truck Driver		Construction Co			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY - HWY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Maryland		Worcester		Newark							
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Ernest Lee Nicholson Sr.						Eliza					Lank
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			Address		
No			213 125628			Betty Lee Nicholson, Newark Md.					
1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CONGESTIVE CARDIAC FAILURE										2 WKS	
492X DUE TO, OR AS A CONSEQUENCE OF (b) ADVANCED PULMONARY EMBOLISM										10 YRS	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
SECONDARY PULMONARY EMBOLISM ARTERIALIZED PULMONARY TUBERCULOSIS											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, etc) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from NOV 19 64, to JUN 16, 1969, that (we) lost saw the deceased alive on JUN 13 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (I) (did not) view the body after death.											
22b. SIGNATURE Robert C. LaMar, M. D.						DEGREE ATTENDING PHYS		<input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6-18-69	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
Robert C. LaMar, M. D.						104 Bay St., Snow Hill, Md. 21863					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		June 19, 1969		Evergreen Cemetery		Berlin, Md.					
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Robert E. Gorman, Snow Hill, Md.						JUN 23 1969		William J. Gorman			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										09181	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										09181	
1 DECEASED-NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF EST. <input checked="" type="checkbox"/> Month Day Year			2b HOURS M		
EDWARD			WILLIS			REDDEN			June 9 1969 2:15		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	7 UNDER 1 YEAR MONTHS DAYS	8 IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month Day Year			2d HOURS M		
Male	White	4-4-1898	71 YRS			June 9 1969			5:10		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			Md		
Maryland		U.S.A.				WORCESTER					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (if not in hosp. tol give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY		
Pocomoke City			Broad Street			Farmer			Farming		
13a USUAL RESIDENCE (Where deceased lived, if institution an Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		
Maryland			Worcester		Pocomoke				821 Second Street		
14 FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
John Purnell Redden			Cordelia -- Mason								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO.		17 INFORMANT			ADDRESS			
No			218-12-1661		Mrs Thelma F. Redden Pocomoke City, Md.						
18 CAUSE OF DEATH (Enter an y one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 minute Several years											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.				City or Town		County Store	
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		Lloyd O. Long, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED		June 11, 1969	
EXAMINER'S NAME (Type)		104 N. Bay St., Snow Hill, Md. 21863				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY		23d LOCATION (City or Town)		(County)		(State)	
Burial		6-11-1969		Beth Eden Cemetery		Worcester County, Maryland					
24 FUNERAL DIRECTOR				ADDRESS				25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Robert H. Watson				Pocomoke City, Md.				JUN 16 1969		W. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

09189

CERTIFICATE OF DEATH

Reg. Dist. No. 09182

1. PLACE OF DEATH a. COUNTY <u>Worcester - Maryland</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin Maryland</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5 Baker St. (Home)</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>William E. Thomas</u> First Middle Last 4. DATE OF DEATH <u>June 25,</u> 19 <u>69</u> Month Day Year															
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 25, 1876</u> <u>93</u> yrs.		9. AGE (In years last birthday) <u>93</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer - Country</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>				11. BIRTHPLACE (State or foreign country) <u>BERLIN MD</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>JAMES E. THOMAS</u>						14. MOTHER'S MAIDEN NAME <u>HETTIE MARY POWELL</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>				16. SOCIAL SECURITY NO <u>218-14-4572</u>				17. INFORMANT <u>Ann A. Fisher</u> Address <u>Berlin Maryland</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chr. Myocarditis</u> <u>72X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO (b) <u>—</u> DUE TO (c) <u>—</u>										INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)											
20c. TIME OF INJURY Month, Day, Year Hour <u>—</u> o. m. <u>—</u> p. m. 19 <u>—</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from <u>1968</u> , 19 <u>—</u> , to <u>6-25</u> , 19 <u>69</u> , that I last saw the deceased alive on <u>6-25</u> , 19 <u>69</u> , and that death occurred at <u>10:05 PM</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>Frank Lewis</u> M.D. <u>Maryland</u> ADDRESS (Street, city or town, state) <u>—</u> DATE SIGNED <u>—</u> PHYSICIAN'S NAME (Type) <u>Frank Lewis</u>															
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>6-28-69</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bucyrus Cemetery</u>				22d. LOCATION (City, town, or county) <u>Berlin Wor Md</u> (State) <u>md</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burbyce</u> ADDRESS <u>Berlin Md</u>						24a. REC'D BY REGISTRAR <u>JUL 1 1969</u>		24b. REGISTRAR'S SIGNATURE <u>William J. Judge</u>							

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-100. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09190

09183

1 DECEASED NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> Month	Day	Year	2b HOUR	
Grant		Drew		Walker	ESTIMATED <input type="checkbox"/>		6	16	1969	9:40	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS HOURS	MIN	2c DATE PRONOUNCED DEAD		2d HOUR	
Male	White	9-16-19	49 YRS					Month 6 Day 18 Year 1969		9:50	
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		A.L.			
Virginia		U.S.A.				Worcester		Md			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Berlin		Ocean City Blvd.				Laborer		Poultry			
13a USUAL RESIDENCE (Where deceased lived, if not institution: Residence before admission) STATE			13b COUNTY	13c CITY OR TOWN		3d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER			
Md.			Wicomico	Fruitland				Brown Street		Plant	
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First	Middle	Last
Drew					Walker	UNKNOWN					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown)			16b SOCIAL SECURITY NO		17. INFORMANT (wife)			ADDRESS			
No			266-05-3359		Mrs. Marian Walker			Brown Street Fruitland, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Clifford E. Schott</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b DATE SIGNED			
EXAMINER'S NAME (Type) Clifford E. Schott, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				Acting 6-16-69			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county) Worcester			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c. NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)					
Burial		6-19-1969		George Washington Cem.		Hyattsville, Prince George G					
24 FUNERAL DIRECTOR				ADDRESS				25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Hill Funeral Home Salisbury, Maryland								JUN 19 1969		Richard J. Judge	



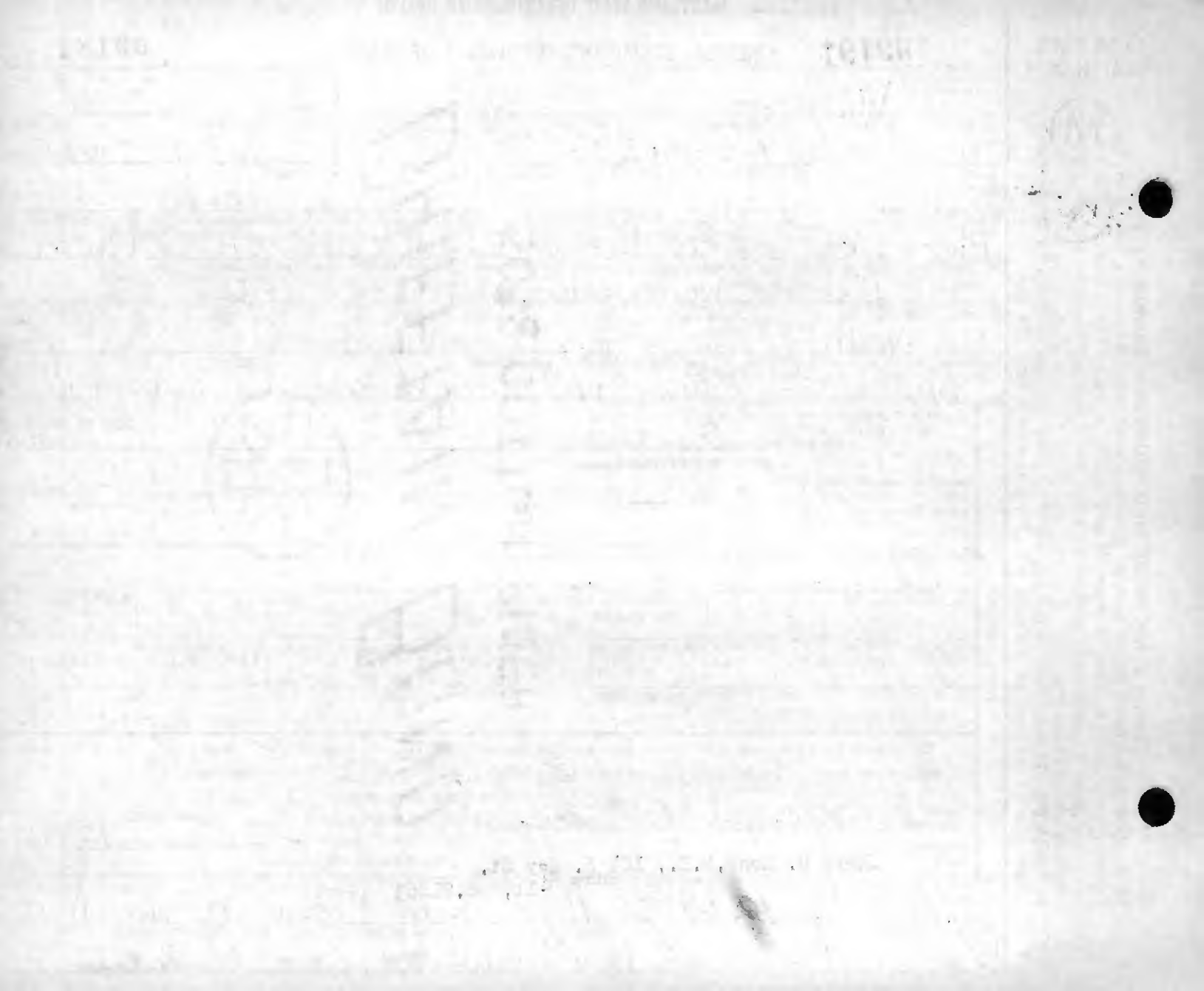
FOR STATE HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MD. 21201
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with item 18.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH										09184	
1. DECEASED-NAME (Type or Print) <u>William</u> First <u>Waters</u> Middle Last						2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> <u>June 7</u> 19 <u>69</u> Month Day Year		2b. HOUR <u>M</u>			
3. SEX <u>Male</u>	4. RACE <u>Negro</u>	5. DATE OF BIRTH <u>7-6-1903</u>	6. AGE (In years lost birthday) <u>65</u> YRS.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD <u>June 10</u> 19 <u>69</u> Month Day Year		2d. HOUR <u>M</u>			
7a. BIRTHPLACE (State or foreign country) <u>Md.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Worcester</u>					
10. CITY OR TOWN OF DEATH <u>Pocomoke</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Rural Pocomoke</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Laborer</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Md.</u>		13b. COUNTY <u>Worcester</u>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET AND NUMBER <u>R.F.D.I</u>					
14. FATHER'S NAME First <u>Nathan</u> Middle <u>Waters</u> Last <u>Sarah</u>		15. MOTHER'S MAIDEN NAME First <u>Bishop</u> Middle <u>Waters</u> Last <u>Waters</u>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16b. SOCIAL SECURITY NO. <u>212-18-6789</u>		17. INFORMANT <u>Harry Waters</u>		ADDRESS <u>Pocomoke, Md.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation</u> <u>910.9</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if only, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Drowning</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Alcohol intoxication</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 minutes</u> <u>4 minutes</u> <u>1-2 hours</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Chronic Alcoholism Alcoholism</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <u>Not</u>		21b. TIME OF INJURY Month, Day, Year <u>Approx. P.M. June 7, 1969</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u>Probably fell off piling he was sitting on at edge of river.</u>							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>Pocomoke River</u>		21f. LOCATION Street or R.F.D. No. <u>--</u> City or Town <u>Pocomoke</u> County <u>Worcester</u> State <u>Md.</u>							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Lloyd O. Long</u>		EXAMINER'S NAME (Type) <u>Lloyd O. Long, M.D., 104 N. Bay St.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>June 12, 1969</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>6-12-69</u>		23c. NAME OF CEMETERY OR CREMATOR <u>Tindley's Cem.</u>		23d. LOCATION (City or Town) <u>Pocomoke</u> (County) <u>Wor.</u> (State) <u>Md.</u>					
24. FUNERAL DIRECTOR <u>James Lavelle</u>		ADDRESS <u>New Church, Va.</u>		25a. REC'D BY REGISTRAR <u>JUN 16 1969</u>		25b. REGISTRAR'S SIGNATURE <u>William R. Jones</u>					

1-100

1000



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, at removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div>09192</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>09185</div>									
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR
ROBERT RANDALL WEAVER						<input checked="" type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year 6 - 16 1969			8:00 M
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year	
Male	White	2-2-1890	79 YRS.					6 16 1969	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Pennsylvania		U.S.A.				WORCESTER			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Pocomoke City			Clarke Avenue & Willow Street			House Painter			General Painting
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Maryland			Worcester			Pocomoke		Clarke Ave. & Willow Street	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
John -- Weaver			-unknown-						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			
No			214-16-4508			Nelson Weaver, Dover, Pennsylvania			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CORONARY OCCLUSION</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4109</u> (b) <u>ARTERIO SCLEROTIC HEART DISEASE - 5 yrs</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED			
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			6/16/69			
Robert C. LaMar, M.D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			104 Bay St., Snow Hill, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City or Town) (County) (State)			
Burial		6-19-1969		East Berlin Cem.		East Berlin-Adams-Penna.			
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Robert H. Watson Pocomoke City, Md.				JUN 18 1969		Charles Judge			

1. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a detailed description of the methodology used in the study. This includes a description of the data collection methods, the statistical methods used for data analysis, and the experimental procedures used to test the hypotheses. The third part of the report is a discussion of the results of the study. This includes a description of the findings, a comparison of the results with previous studies, and a discussion of the implications of the findings. The fourth part of the report is a conclusion and a list of references. The conclusion summarizes the main findings of the study and provides a final statement on the project. The references list the sources of information used in the study.